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Secretary

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Acting Commissioner

SARP: PROVIDER ASSESSMENT DATA FORM

This form is to be completed by:

- A licensed, board certified psychiatrist (MD/DO) who is certified by the American Board of Psychiatry and Neurology in the subspecialty of Addiction Psychiatry (Addiction Provider); or
- A Psychiatric Clinical Nurse Specialist with an additional certification credential from Addictions Nursing Certification Board or the American Academy of Health Care Providers in the Addictive Disorders (CNS); or
- A Board certified Psychiatric Certified Nurse Practitioner with an additional certification credential from Addictions Nursing Certification Board or the American Academy of Health Care Providers in the Addictive Disorders (PMHNP-BC); or
- A licensed Physician, licensed Physician's Assistant, licensed Medical Nurse Practitioner or licensed Psychiatric Mental Health Nurse Practitioner (CNP) with experience, as evidenced by submission of a current curriculum vitae, in the performance of evaluations of substance use disorders and corresponding clinical findings (MD/DO/PA/NP).

What is the name of Licensee/patient:

_____ _____
Name of Provider and Credential Provider License Number

_____
Agency (if applicable)

_____ _____
Signature of Provider Date Phone Number

_____ _____
Address Fax Number

Section I: To be completed by the designated provider and the Licensee

Initially review the information provided by the SARP Applicant in Part I to assure that the data is complete. Please assist the applicant in completing any items that are incomplete or not fully understood as well as those that need additional information. Data provided by the applicant may provide the basis for further assessment and additional questions by you.

ALCOHOL AND DRUG USE HISTORY

Please complete the following sections related to any use of the substances listed.

Substance	**First Use: Date & Age**	**Pattern of use**	**Avg. amt. used/mode of admin**	**Highest dose ever used**	**Last use: date & amt.**
Alcohol					
Cannabis					
Sedative/ Hypnotic					
Cocaine					
Stimulants (list)					
Narcotics (list)					
Nicotine/ Caffeine					

Substance	First Use: Date & Age	Pattern of use	Avg. amt. used/mode of admin	Highest dose ever used	Last use: date & amt.
Hallucinogens					
Tranquilizers					
Solvents (list)					
Anabolic Steroids					
Other (i.e muscle relaxers, antihistamines)					

If applicable, please supply additional information about the Licensee's substance use history in the space below. Please use additional pages as needed.

Section II: This section to be completed by the provider and the Licensee. Please use additional pages as needed.

The MA Substance Abuse Rehabilitation Program (SARP) is a multiyear, structured, program that requires daily check-ins, randomly selected and observed toxicology screens, expectation to do therapy work and attend several community-based sobriety meetings, and completion of monitoring documents from clinicians and employers. Considering your treatment plans, how might you benefit from SARP?

Rank	**Q.** What are the individual's **strengths and skills**?
1	
2	
3	
4	
5	

Rank	**Q.** What prominent **risk/barriers** may prevent the individual to complete the program?
1	
2	
3	
4	
5	

Priority	**Q**. What are the **treatment areas/identified problems**?
1	
2	
3	
4	

Section III: Mental Status Exam (MSE) completed by the provider
Please answer with an "x" if absent, present, or NA.

Appearance	Absent	Present	NA
Unkempt, unclean, disheveled			
Clothing and/or grooming atypical			
Unusual physical characteristics			
Mood	**Absent**	**Present**	**NA**
Labile			
Euphoric, elevated			
Depressed, sad, sullen			
Anxious			
Angry, hostile			
Perception/Orient/Cognition	**Absent**	**Present**	**NA**
Perception: delusions			
Perception: auditory hallucinations			
Perception: visual hallucinations			
Perception: other hallucinations			
Disoriented to person			
Disoriented to place			
Disoriented to time			
Impaired recent memory			
Impaired remote memory			
Impaired consciousness			
Impaired attention span			
Impaired abstract thinking			
Impaired calculation ability			
Impaired intelligence			
Impaired impulse control			

Motor/Affect/Speech/Relate	Absent	Present	NA
Posture: slumped			
Posture: rigid, tense			
Affect: anxious, fear,			
Affect: angry			
Affect: incongruent to mood			
Affect: constricted, blunted			
Movement: accelerated/fast			
Movement: decreased/slow			
Movement: atypical/unusual			
Movement: restless, fidget			
Speech: rapid			
Speech: loud			
Speech: soft			
Speech: mute			
Speech: atypical			
Relatedness: dependent			
Relatedness: submissive			
Relatedness: provocative			
Relatedness: hostile			
Relatedness: domineering			
Relatedness: guarding			
Relatedness: uncooperative			
Thought	**Absent**	**Present**	**NA**
Obsessions			
Compulsions			
Phobias			
Delusional			
Depersonalization			
Suicidal ideations			
Homicidal ideations			
Disorganized thoughts			

As needed, please expand on the MSE in the space below:

Section IV: Completed by the provider. Please use additional pages as needed.

How long have you been working with this individual for?

What is the individual's perception of their substance use? Briefly discuss their insight and judgement.

Briefly describe the individual's motivation for treatment:

What is your clinical impression and diagnoses? How would you categorize the severity of their substance use?

Please supply any information not covered in this form which you or the applicant thinks might be important and helpful to the Committee in reviewing his/her case:

What are your recommendations? Please utilize the table below.

RECOMENDATIONS	
☐Community level of care with	
Individual: ☐Weekly therapy sessions. # of: ☐Biweekly sessions ☐As needed sessions Family treatment: ☐Encourage spouse to attend Al/Nar-Anon ☐Co-dependency counseling ☐Family therapy sessions ☐Specify other: Additional: ☐Relaxation, meditation ☐Pain management clinic ☐Education: Addictions, Mental health	Groups: ☐Attend # of AA/NA meetings per week ☐Obtain a sponsor or ☐ continue with current sponsor ☐Join home group or ☐ continue with current group ☐Attend AWOL group or ☐ attend early recovery group ☐Join gender-based group ☐Attend a professional support group ☐Attend Rational Recovery group ☐Specify other group:
OR	**Please describe as needed**
☐Intensive outpatient program	
☐Partial Hospitalization program	
☐Inpatient	

The summary of information from this and other documents submitted to SARP is used to make a decision regarding the Licensee's ability to comply with the program. Given the Licensee's history and your assessment, please supply your estimation of the Licensee's likelihood to comply with the program: (check one)

☐Very Likely ☐ Somewhat likely ☐ Unlikely ☐ Very unlikely

As you consider your treatment plan with the Licensee/patient, please know that certain therapeutic agents ***may*** be permitted in the program with strong supportive documentation of medical necessity. Permission to enter and continue the program with certain agents is gained after being heard before the Substance Abuse Rehabilitation Evaluation Committee (SAREC) and the Board of Nursing. Below are some documentation *examples* a Licensee may be expected to submit prior to being heard to enter SARP with certain therapeutic agents:

+ The SARP Prescription Verification and Medical Necessity Form.
+ A neuropsychiatric evaluation report as it applies to respective diagnoses.
+ Letter from prescriber describing course of treatment and symptom management with impact on functioning while using the agent and the result of other medication trials as applicable.
+ Letter from Licensee detailing impact on functioning with and without use of the agent.